PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV MEETING
Gaborone, Botswana, 27-31 March 2000
Draft recommendations for scaling-up interventions in pilot countries

Preamble

The HIV/AIDS epidemic is resulting in more than 600,000 infants becoming infected each year, and in many countries HIV/AIDS has become a major cause of infant and young child mortality. From a human rights perspective, governments and UN agencies have an obligation to support action to prevent infants becoming infected.

Since the PMTCT initiative was launched in 1998, it has become clear from the increasing scientific evidence and recent results from countries such as Botswana, Cote d'Ivoire, Uganda, Rwanda and Zimbabwe, that it is possible to make a difference.

At country level, more national leaders and governments are recognising the seriousness of the situation and are creating a supportive political environment by setting up National HIV/AIDS Council and Secretariats and committing government resources to the response to HIV/AIDS. Within the framework of the International partnership Against HIV/AIDS in Africa, a number of international agencies (UNICEF, WHO, UNFPA) under the coordination of UNAIDS, have already demonstrated their commitment to supporting interventions aimed at preventing the mother-to-child transmission of HIV in Africa. Some countries are moving from pilot projects to scaling-up.

However, the current actions are clearly not enough. There is an urgent need for more countries to start implementing PMTCT interventions on a national scale in order to have a meaningful impact. In addition, the participation in the planning and carrying out of PMTCT interventions should be broadened to increase support for HIV-positive women, and encourage stronger involvement of males and people living with HIV/AIDS.

In short, a much more substantial response to MTCT of HIV is needed urgently from all actors – governments, NGOs, local communities, the private sector and international development organisations.

In light of the above situation, participants from 14 countries in Africa, Latin America and the Caribbean representing government and NGOs met in Gaborone, Botswana, from 27-31 March 2000 with the specific objectives of taking stock of the present status of implementation of interventions for the prevention of MTCT of HIV, and proposing appropriate corresponding actions.

The meeting agreed that goals for the PMTCT initiative should be set in the near future. Participants also agreed on the following recommendations:

GENERAL

Countries should be supported in accelerating implementation of PMTCT programmes.

1. Countries that have been in the process of planning for PMTCT for the last one to two years should start implementation of the programme now. For those countries that have started, there is an urgent need to move beyond pilots to national, phased scaling-up.

2. Participation in the planning and implementation of PMTCT programmes should be broadened to increase community support for HIV+ women, and encourage stronger involvement of males and PLWH/As.

3. All cadres of health workers should be involved in the planning, implementation and monitoring of PMTCT programmes in order to influence acceptance of the intervention and enhance motivation.

4. PMTCT should be approached holistically, with the specific aim of integrating all elements of the programme into routine health services.

5. There is a need for senior level political commitment, and governments should also commit resources to agency-assisted efforts.

6. The initial planning and implementation of PMTCT programmes has identified several additional research priorities:

- monitoring resistance to nevirapine and other ARVs used in PMTCT and the long-term implications of this;
- the application of new testing technologies and therapies;
- acceptance of different models of counselling interventions;
- feasibility of various infant feeding options in local settings;
- continuous research on use of ARVs in infants to prevent post-natal transmission of HIV.

7. Many innovative approaches (e.g. to VCT) are being developed, and countries should be given opportunities to evaluate, document and share their experiences. This process should be supported through provision of inter-country technical support, field visits, joint training and networking within sub-regions.

INFANT FEEDING

Clearer advice and support of feeding options should be given to HIV-positive women.

8. National programmes, with the support of the UN co-sponsors under the coordination of UNAIDS and in collaboration with other partners, should ensure that:

- training on infant feeding for all health workers who care for mothers and babies, including PMTCT counsellors, is strengthened and accelerated. Training should include breastfeeding counselling, complementary feeding, infant feeding in MTCT, and replacement feeding options;
- breastfeeding specialists are more actively involved in training for infant feeding ling as part of PMTCT;
- the community and PLWH/As are included in the development of infant feeding policies and guidelines;
- messages are consistent between related programmes (e.g. IMCI);
- counselling on infant feeding and PMTCT is designed to enable the mother, in consultation with the health worker, to decide on the infant feeding option most feasible for her and best for her infant. The aim of the counselling should not just be to give information, but to empower the mother to assess the appropriateness of the alternatives to her specific situation.

COMMUNICATION

Programmes should ensure political commitment and create demand for VCT/PMTCT at the community level.

9. Countries' capacities to develop and implement appropriate communication strategies on PMTCT will be strengthened.

10. Advocacy at all levels should be stepped up, with the focus on PMTCT as a human rights issue.

11. Best practices on stigma reduction should be developed and disseminated.

12. Inter-personal communication skills training packages for district staff should be identified and reviewed.

13. Special efforts to should be made to achieve male involvment.

14. MTCT communication interventions should be integrated within the overall HIV/AIDS communication programme, with primary prevention efforts continued and strengthened.

VCT

Access to VCT should be expanded rapidly.

15. VCT is a part of comprehensive care and prevention for women who test seropositive or seronegative. Active links with other counseling services outside ANC testing, as well as services

for TB, STDs and IMCI, should be developed to ensure that women, their partners and families have access to follow-up counseling and care where needed.

16. The counselling component of VCT is often seen as being time consuming, adding to already heavy workloads, difficult and emotionally draining. There are many ways of sharing the counselling load, ensuring that counsellors are supported and the quality of counselling guaranteed:

- Broader recruitment of counsellors to include, PLWH/As, lay and volunteer counselors;
- More appropriate training in basic counselling skills;
- Training follow-up focussing on skills for managing adjustment and difficulties following breaking bad news;
- Better professional support for counsellors' roles;
- Supervision to ensure higher and maintained counselling quality;
- Community referral networks for ongoing counselling and psychosocial support of those adjusting to HIV;
- Shorter pre-test counselling/no pre-test counselling where appropriate and where information from other sources is adequate;
- Exploring counseling models complementary to human resource availability.

TESTING

Efforts should be made to streamline testing and to maintain quality control.

17. Given the increasing evidence of good experiences with rapid tests, countries should be encouraged to integrate them into testing algorithms to increase PMTCT programme uptake.

18. Clear guidelines should be provided regarding:

- availability and appropriateness of testing kits for different HIV strains and prevalence rates;
- quality control;
- training of health workers to enable disseminated use of rapid tests at primary health facilities;
- algorithm for diagnosis of HIV infection in young children.

19. There should be regional coordination on:

- procurement of kits, i.e. negotiating costs;
- monitoring of resistance.

20. Quality control must be maintained.

ARVs

Countries need continual guidance in the provision of ARVs for MTCT.

21. The use of ARVs for PMTCT should be based on knowledge of the woman's HIV status.

22. There should be continued advocacy at global, regional and country level for access, affordability and availability of ARV drugs for PMTCT.

23. WHO should clarify its recent statement on nevirapine to give countries better guidance on the use of this drug.

CARE AND SUPPORT

Ensure that in PMTCT programmes, HIV-positive mothers have access to the best available care.

24. PMTCT programmes should strive for a continuum of care, and be seen as an entry point so that HIV-infected women have access condoms and to screening for, and prophylaxis and/or treatment of STDs, tuberculosis and other opportunistic infections as these services become available.

25. PMTCT programmes should promote establishment of linkages for care and support of orphans.

SUPPLIES

Reliability of the provision of drugs, test kits and breast-milk substitutes should be improved.

26. Forecasts should be made of the quantities of supplies required for the next two years.

27. Best prices should be negotiated for commodities.

MONITORING AND EVALUATION:

PMTCT implementation needs to be monitored and documented so that lessons can be learned, experiences can be shared and scaling up can be done effectively. While governments have the primary obligation to monitor their programmes, UN agencies also have a responsibility for the adequate funding and technical support in the area during the development and early implementation phase. Specically, agencies can support the Government to:

27. Design simple and practical monitoring plans compatible with available human resources in the health facilities. These plans should cover mainly the monitoring of the program uptake and could leave impact and extended evaluation for focused assessments.

28. Improve the capacity to monitor the interventions at facility level

29. Support the country manpower and logistical needs in order to implement these simple monitoring plans.

30. Support a simple monitoring of the scaling up phase in order to learn lessons on how to expand.